sprouts Therapy

**Client Information Form**

Client Name: _____

Client Gender: _____

Date of Birth: _____

Childs Diagnosis: _____Date of Onset (Required for insurance purposes): _____

Referring Provider: _____

Mothers Name or Guardian: _____

Address (Street, City, State, Zip): _____

Phone Number Home: _____ Cell: _____

Email Address: _____

Fathers Name or Guardian: _____

Address (Street, City, State, Zip): _____

Phone Number Home: _____ Cell: _____

Email Address: _____

Additional Care Giver Name and Phone Number: _____

Emergency Contact Name and Phone Number: _____

Pediatrician or Family Doctor Name and Phone Number: _____

Emergency Medical Info (Allergy, Epi Pen, Seizure): _____

Please provide your availability for treatment sessions: (i.e. daytime, weekdays, weekends, evenings etc.)

## Therapy Treatment Program Agreement

**Mission Statement.** Sprouts Therapy, LLC is a pediatric habilitation program offering intensive therapy services around the island of Oahu, Hawaii. We provide brain, motor and sensory-based treatment promoting independence, community integration, fine/gross motor skill development, feeding skills, communication, social skill development and self regulation. We are therapist-operated and committed to providing the highest quality of therapy to clients with a variety of disabilities.

**Services.** Sprouts Therapy services may consist of multiple locations.
Session Locations: Sprouts Therapy Clinic, Home, Community and School settings
Sprouts Therapy Clinic is located at: 1210 Wilhelmina Rise, Unit A2 & B, Honolulu, HI 96816.

**Financial Agreement.**

*Private Pay/Out of Network Insurance clients:* I, the client or parent/legal guardian of the client, understand that I am responsible for all charges for services provided to me or my child by Sprouts Therapy. I have been notified that it is my responsibility to contact my insurance carrier to determine whether services by Sprouts Therapy meet the reimbursement criteria and whether preauthorization is required. Preauthorization for services may be required prior to submitting claims to insurance carriers. The client or the parent/guardian is responsible for obtaining preauthorization, although Sprouts Therapy will provide written information and documentation in order to facilitate the process if requested (documentation fees may apply.) I agree to pay Sprouts Therapy for evaluation fees at the time of report delivery (PDF via email). I agree to pay Sprouts Therapy for all treatment and additional services upon services rendered. We accept VISA, Master Card, AMEX and Discover. The above fees will require Sprouts Therapy to have a credit card on file to charge for private pay services and cancelation fees.

*In-Network Insurance Clients:* Preauthorization for services may be required prior to submitting claims to in-network insurance carriers. If preauthorization is required, services shall not be provided until preauthorization has been approved. Sprouts Therapy will bill insurance carrier upon services rendered. I, the client or parent/legal guardian, understand that I am responsible for all charges for services not covered by my insurance, as well as coinsurance, deductibles and copays, and that payment for these uncovered services and patient responsible fees will be due upon insurance denial of claims or completion of claim processing. Sprouts Therapy requires a credit card on file for each client to charge in the event of uncovered services rendered, coinsurance, copays, deductibles and/or cancelation fees. We accept VISA, Master Card, AMEX and Discover. Uncovered services will be billed at the private pay rates, unless an insurance eligible charge applies.

*Refund Policy:* In the event that it is necessary for Sprouts Therapy to issue a refund, a credit memo will be created and applied to the following invoice. If there will not be a subsequent invoice, then a refund will be made to the card that was charged. Refunds may be given upon authorization by Sprouts Therapy, which will be determined on a case-by-case basis.

**Therapy Treatment Consent.** I, the client or parent/legal guardian of the client, acknowledge that I have reviewed the description of the therapy program and I hereby consent to the administration of reasonable and necessary services in connection with the therapy program. I acknowledge that no guarantees have been made to me as to the results of the therapy program treatments. I acknowledge that I am not guaranteed time slots or environments and at any time Sprouts Therapy can terminate services.

**Medical Costs.** I shall be liable and agree to pay all costs and expenses incurred in connection with any medical, dental or other related services rendered to client as a result of injuries incurred during evaluation and treatment.

**Assignment of Benefits**. I hereby authorize and assign payment directly to Sprouts Therapy for benefits, including secondary benefit, due for therapy services. I understand that I am financially responsible for charges not covered by any insurance or medical benefit payer. I further acknowledge that any benefits, when received by and paid to Sprouts Therapy, will be credited to my account in accordance with the assignment.

**Release and Hold Harmless.** I do hereby release and agree to indemnify, protect and hold harmless, Sprouts Therapy and its therapists and volunteers, and all private persons or organizations providing services for Sprouts Therapy from any claim or liability whatsoever, including, but not limited to, personal injury, death, property damage, court costs, attorney fees and interest, however caused, including the negligence of Sprouts Therapy, as a result of the clients participation in activities.

**Permission.** I agree to permit the client or myself to participate in the Sprouts Therapy Program and the additional therapeutic activities, including but not limited to gym activities, swimming, and/or any type of community integration or recreational activity. I hereby give permission for the client or myself to receive services and treatment by Sprouts Therapy. I authorize the release of information, including protected health information as needed to file for payment for services incurred. I fully understand my financial responsibility for services rendered by Sprouts Therapy.

Your signature below verifies that you have received a copy of the Private Pay and Cancelation Fees, and have read and agree to the statements of this contract and the prices for Sprouts Therapy Services.

**Name of Client:**_____ **Date of Birth:** _____

**Name of Parent/Guardian:** _____

**Signature of Parent/Guardian:**_____ **Today's Date:** _____

**Signature of Client (if over 18 years of age):** _____ **Today's Date:** _____

sprouts Therapy

## Insurance Form

***Please be sure to provide a copy of your Insurance ID Card***

| | | | |
|---|---|---|---|
| Primary Insurance Company | | Client ID | |
| Client Name | | Client Date of Birth | |
| Policy/Group | | Plan/Program (HMO / PPO) | |
| Sponsor Name | | Sponsor Date of Birth | |
| Relationship to Client | | SSN# (Tricare only) | |
| Employer | | Position/Title | |

| | | | |
|---|---|---|---|
| Secondary Insurance Company | | Client ID | |
| Policy/Group | | Plan/Program (HMO / PPO) | |
| Sponsor Name | | Sponsor Date of Birth | |
| Relationship to Client | | SSN# (Tricare only) | |
| Employer | | Position/Title | |

☐ Please check here if you do not have insurance/ will not be submitting claims to insurance for therapy services

## In-Network Providers:

**TRICARE:** Sprouts Therapy is a contracted provider with Tricare insurance. Before beginning services with us, you will need to obtain an authorization through Tricare for occupational and/or speech therapy services. You will need to provide your insurance with a medical referral or prescription from your child's pediatrician in order to obtain this. We do require that you provide a credit card for us to keep on file, which is billed for no show fees, late cancellation fees, late pick up/drop off fees, non-insured sessions and/or co-payments and deductibles. (Music Therapy and Acupuncture services are not Tricare benefits)

- **Tricare Prime Clients**: We will charge Tricare for services rendered. No shared cost if Sprouts Therapy is the servicing provider on authorization. You will be responsible for any deductibles and non-covered services.
- **Tricare Standard Clients:** We will charge Tricare for services rendered. Each session will have a coinsurance until deductible and annual out of pocket maximum is met. You will be responsible for all co-pays, deductibles and non-covered services.

**UNITED HEALTHCARE (Commercial Plans), CIGNA and AETNA:** Sprouts Therapy is a contracted provider with AETNA, Cigna and United Healthcare Commercial Plans. Please contact your insurance company for specifics regarding therapy benefits. We will bill your insurance company for services rendered. We do require that you provide a credit card for us to keep on file, which is billed for no show fees, late cancellation fees, late pick up/drop off fees, non-insured sessions and/or co-payments and deductibles. (Music Therapy and Acupuncture services not included in benefits)

## Out of Network Providers:

*Sprouts Therapy does not accept payment from out-of-network insurance companies. Preauthorization for services may be required prior to submitting claims to insurance carriers. The client or the parent/guardian is responsible for obtaining preauthorization, although Sprouts Therapy will provide written information and documentation in order to facilitate the process if requested (documentation fees may apply). The client or the parent/guardian is responsible for all charges for services provided to themselves or their child by Sprouts Therapy. It is the responsibility of the client or the parent/guardian to contact their insurance carrier to determine whether the services by Sprouts Therapy meet the reimbursement criteria and whether preauthorization is required. Sprouts Therapy will provide coded invoices to clients for direct submittal purposes.*

☐ **Please check here if you will be submitting your claims to insurance directly**

☐ **Please check here if you would like Sprouts Therapy to submit claims (initial allowed sessions + pre-authorized sessions) to your insurance company on your behalf. This service has a fee of $10.00/session that will be added to your invoice from Sprouts Therapy. Understand that this service does not guarantee reimbursement, and that you are responsible for all disputes with your insurance company regarding coverage and reimbursement.**

**UHA:** UHA will not typically provide any reimbursement for services at Sprouts Therapy. All SLP sessions require prior authorization ahead of time.
Self Submit Helpful Information: https://uhahealth.com/page/faqs-for-member

**HMAA:** HMAA typically allows 10 OT sessions with reimbursement directly to the subscriber before a prior authorization is required. All SLP sessions require prior authorization ahead of time.
Self Submit Helpful Information: http://www.hmaa.com/wp-content/uploads/2012/11/CMS1500.pdf

**HMSA: HMSA PPO** plans typically allow 8 OT sessions (evaluation and treatment sessions) and 1 SLP evaluation for partial reimbursement directly to the subscriber before a prior authorization is required (Roughly $80-$100 for OT/SLP Evaluations, and approximately $90-$100 for OT treatment sessions). All SLP treatment sessions require prior authorization ahead of time. (If your child has an Autism diagnosis, we may be able to secure additional OT, PT and/or SLP treatment sessions for reimbursement through prior authorization requests.)
Self Submit Helpful Information: https://hmsa.com/help-center/filing-medical-claims-for-services-from-nonparticipating-providers/
**HMSA HMO** clients typically receive no reimbursement for services at Sprouts Therapy.

**KAISER:** Kaiser will not provide any reimbursement for services at Sprouts Therapy.

**ALL OTHER INSURANCE CARRIERS:** We are an out-of-network provider for HMA, Medicaid, Medicare, Quest and all other insurances not previously listed above. Please contact your insurance company to verify your benefits.

## Financial Agreement

I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all the services rendered to me by Sprouts Therapy and its practitioners. I also understand that all out-of network (non-contracted) insurance billing services provided by Sprouts Therapy on my behalf can be discontinued by either myself or Sprouts Therapy with written notice at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to the providers(s) at Sprouts Therapy. I understand my co-pay is due at the time of services rendered. I understand that I am financially responsible for the following: excluded benefits of my insurance plan, services that do not meet the payment determination criteria of my insurance company, parent education, school/teacher consultations, services deemed not medically necessary by my insurance company, services not approved by my insurance company (i.e. Speech and Language Therapy, Occupational Therapy, Feeding Therapy, Music Therapy, Acupuncture, Vision Therapy), procedure codes not approved by my insurance company, procedure codes that exceed my insurance's allowed units per day, no show fees, cancelation fees, copays, coinsurance, and deductibles.

A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature_____

_

Print Name_____Date:_____

Client Name_____

**Pediatric Therapy Pre-Evaluation Release**

Sprouts Therapy will conduct your child's evaluation with professionalism and care. Please inform us if you believe your child may respond with aggressive behavior for the safe handling of your child and the safety of the therapist.

I do hereby release and agree to indemnify, protect and hold harmless, Sprouts Therapy and its therapists and volunteers, and all private persons or organizations providing services for Sprouts Therapy from any claim or liability whatsoever, including, but not limited to, personal injury, death, property damage, court costs, attorney fees and interest, however caused, including the negligence of Sprouts Therapy, as a result of the clients participation in a Therapy Evaluation.

I also acknowledge receipt of the initial feeding evaluation parent letter and understand and agree to its contents.

By signing below, you agree to all of the above.

**Name of Child:**

_____

**Date of Birth:**

_____

**Name of Parent/Guardian:**

_____

**Signature of Parent/Guardian:**

_____

**Today's Date:**

_____

**Authorization to Release Client Information**

For educational, medical, or related purposes I do hereby grant permission to **Sprouts Therapy, LLC** to release documents/information acquired on the client named below:

**Client:** _____

**D.O.B:** _____

**Address:** _____

**Name of Professional/School /Business Permission is granted:**

_____

**Address:**

_____

**Parent/Legal Guardian Signature:** _____

**Print Name:** _____ **Date:** _____

sprouts Therapy
Pediatric Therapy Specialists
1210 Wilhelmina Rise, Unit B
Honolulu, HI 96816 (858) 248-7824

**Please select one of the following (REQUIRED):**

- ◯ My child has an IEP and I have attached a copy along with my intake paperwork
- ◯ My child does not have an IEP and I have filled out the form below

**Individual Education Plan (IEP) ATTESTATION**

Client: _____

Date of birth: _____

My child does not have an IEP for the following reason:

- ◯ Home Schooled
- ◯ Attends Private School
- ◯ Does not yet attend school due to young age
- ◯ In public school but does not qualify for an IEP
- ◯ My child's IEP/Qualification meeting is in process/scheduled for a later date
- ◯ Other: (Please describe)

_____

_____

_____

Please proceed with authorization request for continued therapy services.

Parent Signature: _____

Date:_____

Parent Name Printed: _____

## Health Insurance Portability and Accountability Act (HIPAA)
## Notice of Privacy Practices for Protected Health Information

Receipt and Acknowledgment of Notice

**Client Name:** _____

**DOB:** _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Private Practices for Protected Health Information for Sprouts Therapy. I understand that if I have any questions regarding this Notice or my privacy rights, I can contact Crystal Amelang, OTR/L, SIPT.

Signature of Parent or Guardian Date

Relationship to Client

☐ Client Refuses to Acknowledge Receipt

**Credit Card Authorization Form**

**TO BE COMPLETED IN PERSON- DO NOT FILL OUT ELECTRONICALLY**

☐ I hereby give my permission to Sprouts Therapy LLC to process payment on the due date for services rendered, non-insured services, copays/deductibles/coinsurance and/or cancelation fees with the card indicated below. I understand Sprouts Therapy will keep this card on file.

Type of Card: (Circle One)

Master Card VISA American Express Discover

Card Number: _____

Expiration Date: _____ CVV Code: _____

Billing Zip Code: _____ Name on Card: _____

Parent/Legal Guardian/Card Holder Signature_____

Print Name_____

Client Name _____

1210 Wilhelmina Rise •Unit B Honolulu, HI 96816 • 808-260-9056
www.SproutsTherapy.com